		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019976

Facility Name: The Henry and Jane Vonderlieth Living Center, Inc.

Address: 1120 North Topper Drive (Number) Mount Pulaski (City) 62548 (Zip Code)

County: Logan

Telephone Number: (217) 792-3218 **Fax #** (217) 792-3210

IDPA ID Number: 37-0967671001

Date of Initial License for Current Owners: 10/21/1973

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 © (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Helen M. Meagher **Telephone Number:** (217) 735-2549

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Cindy Russell
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Helen M. Meagher, C.P.A.
(Firm Name & Address) Helen M. Meagher, C.P.A.
101 1/2 S. Kickapoo, Lincoln, IL 62656
(Telephone) (217) 735-2549 Fax # (217) 732-8315

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	143			143	8
9	SNF/PED					9
10	ICF	11,248	16,829		28,077	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,391	16,829		28,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.91%

D. How many bed-hold days during this year were paid by Public Aid?
38 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/21/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	230,808	14,688	8,315	253,811	(36,889)	216,922		216,922			1
2	Food Purchase		173,427		173,427	(33,028)	140,399	(3,072)	137,327			2
3	Housekeeping	74,887	21,425		96,312		96,312		96,312			3
4	Laundry	47,560	12,230		59,790		59,790		59,790			4
5	Heat and Other Utilities			94,774	94,774		94,774		94,774			5
6	Maintenance	68,411	16,374	28,999	113,784	2,229	116,013	(255)	115,758			6
7	Other (specify):* SEE PAGE 24			2,556	2,556	(180)	2,376		2,376			7
8	**TOTAL General Services**	421,666	238,144	134,644	794,454	(67,868)	726,586	(3,327)	723,259			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,263,430	69,752	5,536	1,338,718		1,338,718		1,338,718			10
10a	Therapy	60,472			60,472		60,472		60,472			10a
11	Activities	45,768	2,799	6,636	55,203		55,203		55,203			11
12	Social Services	22,478		3,950	26,428		26,428		26,428			12
13	Nurse Aide Training											13
14	Program Transportation			4,737	4,737		4,737		4,737			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,392,148	72,551	20,859	1,485,558		1,485,558		1,485,558			16
	C. General Administration											
17	Administrative	59,927	295	4,478	64,700	(2,229)	62,471	(942)	61,529			17
18	Directors Fees			3,006	3,006		3,006		3,006			18
19	Professional Services			27,739	27,739		27,739		27,739			19
20	Dues, Fees, Subscriptions & Promotions			10,398	10,398	398	10,796	(59)	10,737			20
21	Clerical & General Office Expenses	66,278	7,277	7,979	81,534		81,534		81,534			21
22	Employee Benefits & Payroll Taxes			321,032	321,032	69,519	390,551		390,551			22
23	Inservice Training & Education			25	25		25		25			23
24	Travel and Seminar			1,566	1,566		1,566		1,566			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,441	69,441		69,441		69,441			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,205	7,572	445,664	579,441	67,688	647,129	(1,001)	646,128			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,940,019	318,267	601,167	2,859,453	(180)	2,859,273	(4,328)	2,854,945			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. #0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			206,546	206,546	(45,346)	161,200	6,913	168,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			158	158		158	(158)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					180	180		180			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			206,704	206,704	(45,166)	161,538	6,755	168,293			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):*		682	16,295	16,977	45,346	62,323	(62,323)				43
44	**TOTAL Special Cost Centers**		682	65,570	66,252	45,346	111,598	(62,323)	49,275			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,940,019	318,949	873,441	3,132,409		3,132,409	(59,896)	3,072,513			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,072)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,913	30		9
10	Interest and Other Investment Income	(158)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(59)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(63,520)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,896)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (59,896)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Henry and Jane Vonderlieth Living Center, Inc.

ID# 0019976

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Write off prior years deferred maintenance	$ 5,089	6	1
2	Apartment expenses	(62,323)	43	2
3	Flowers	(917)	17	3
4	Investment expense	(25)	17	4
5	Current year deferred maintenance	(5,344)	6	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,520)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,072)	0	0	0	0	0	0	0	0	0	0	(3,072)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(255)	0	0	0	0	0	0	0	0	0	0	(255)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,327)	0	0	0	0	0	0	0	0	0	0	(3,327)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(942)	0	0	0	0	0	0	0	0	0	0	(942)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(59)	0	0	0	0	0	0	0	0	0	0	(59)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,001)	0	0	0	0	0	0	0	0	0	0	(1,001)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,328)	0	0	0	0	0	0	0	0	0	0	(4,328)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,913	0	0	0	0	0	0	0	0	0	0	6,913	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(158)	0	0	0	0	0	0	0	0	0	0	(158)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	6,755	0	0	0	0	0	0	0	0	0	0	6,755	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(62,323)	0	0	0	0	0	0	0	0	0	0	(62,323)	43
44	**TOTAL Special Cost Centers**	(62,323)	0	0	0	0	0	0	0	0	0	0	(62,323)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(59,896)	0	0	0	0	0	0	0	0	0	0	(59,896)	45

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cent # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Farmer's Bank of Mt. Pulaski		x	Working capital	NONE	3/21/02	30,000	NONE	3/21/03	0.0600	158	6
7												7
8												8
9	TOTAL Facility Related						$ 30,000	$			$ 158	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 30,000	$			$ 158	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ NONE	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Henry and Jane Vonderlieth Living Center, Inc COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0019976

CONTACT PERSON REGARDING THIS REPORT Cindy Russell

TELEPHONE (217) 792-3218 FAX #: (792) 792-3210

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - tax exempt		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,140 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

25 apartments owned by corporation

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building & grounds	2,163,000	1971	$ 55,924	1
2					2
3	TOTALS	2,163,000		$ 55,924	3

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1973	$ 1,172,276	$ 29,307	35	$ 33,494	$ 4,187	$ 931,721	4
5	30		1977	1977	441,636	11,041	35	12,618	1,577	316,239	5
6											6
7											7
8											8
	Improvement Type**										
9	Heating system			1979	3,848		20			3,848	9
10	Conversion			1979	11,345	344	33	344		8,078	10
11	Medicine room			1981	474		20			474	11
12	Fence			1981	921		8			921	12
13	Sidewalks			1981	1,209		20			1,209	13
14	Shower room			1982	1,175	34	35	34		694	14
15	Blacktopping			1983	5,095	255	20	255		4,930	15
16	Landscaping			1984	1,000		10			1,000	16
17	Remodeling			1984	3,117	156	20	156		2,899	17
18	Parking lot			1985	36,890		15			36,890	18
19	Fire hydrant			1985	1,308		15			1,308	19
20	Building improvement			1985	5,201	173	30	173		3,005	20
21	Energy management system			1985	9,381	470	20	470		8,099	21
22	Blacktopping			1986	3,885	194	20	194		3,185	22
23	Shrubs			1986	583		10			583	23
24	Sewer lift station			1986	40,129	2,006	20	2,006		32,263	24
25	Sewer lift station			1987	15,420	771	20	771		12,272	25
26	Windows improvements			1988	4,721		5			4,721	26
27	Fan			1988	1,743		5			1,743	27
28	Office remodeling			1988	1,580	105	15		(105)		28
29	Sealcoating			1989	4,580	305	10		(305)	4,580	29
30	Patio door			1990	985	66	15	66		803	30
31	Trees			1990	700		10			700	31
32	Air conditioner			1991	53,731	3,582	15	3,582		41,492	32
33	Building improvements (ceilings, lift station, temperature controls			1991	16,133		10			16,133	33
34	Building improvements (kitchen floor, sprinklers, fire doors			1991	43,767	2,918	15	2,918		33,946	34
35	Fire alarm panels			1992	4,622	308	15	308		3,337	35
36	Water softner			1992	7,887	260	10	260		7,887	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Walk-in cooler	1992	$ 12,469	$ 623	20	$ 623	$	$ 6,282	37
38	Door monitor system	1992	1,700	156	10	156		1,700	38
39	30 Heating units	1992	9,810	491	20	491		5,278	39
40	Blacktopping	1992	2,859		10			2,859	40
41	Library paneling	1993	3,900	195	20	195		1,869	41
42	Convection units	1993	3,270	164	20	164		1,585	42
43	Asphalt sealcoating	1994	2,809		5			2,809	43
44	Computer room - drywall	1994	2,244	224	10	224		1,923	44
45	Pump	1994	3,439	344	10	344		2,723	45
46	Roof	1995	324,374	12,975	25	12,975		102,518	46
47	Room size heater	1995	1,604	160	10	160		1,267	47
48	Heating system units	1995	9,772	977	20	489	(488)	3,749	48
49	Garage doors	1996	1,550	155	10	155		995	49
50	80 Gallon water heater	1996	7,611	761	10	761		4,820	50
51	Exhaust fan	1997	1,691	169	10	169		845	51
52	Therapy, activity, administration offices, and additional storage	1998	796,976	22,770	35	22,770		108,158	52
53	Additional finish costs (line 52 above)	1998	4,715	135	35	135		641	53
54	Dampers and motor actuator	1998	3,293	165	20	165		811	54
55	Chiller	1998	14,853	743	20	743		3,653	55
56	Moveable wall	1998	9,830	393	25	393		1,670	56
57	Boiler programmer	1998	2,570	129	20	129		634	57
58	80 Gallon water heater	1998	5,287	529	10	529		2,513	58
59	Chain link fence	1999	1,019	68	15	68		238	59
60	Lowered "one head"	2000	2,087	209	10	209		505	60
61	8 Steel universal access doors 24"x24"	2000	437	44	10	44		106	61
62	11 Smoke & fire dampers	2000	21,450	2,145	10	2,145		4,648	62
63	Card zone expander installed	2000	3,185	319	10	319		691	63
64	Floor tile for center corridor & dining room	2000	6,290	419	15	419		864	64
65	Blacktopping drive (from def maint per IDPH review 2000 report)	2000	7,309		5	1,462	1,462	1,462	65
66	Boiler	2001	64,480	3,224	20	3,224		3,761	66
67	4" wall base in corridors & dining room	2001	19,200	1,280	15	1,280		1,387	67
68	12 time delayed locks on outside doors	2002	23,618	202	10	787	585	787	68
69	Boiler room hollow steel door	2002	1,233	29	35	29		29	69
70	TOTAL (lines 4 thru 69)		$ 3,272,276	$ 102,492		$ 109,405	$ 6,913	$ 1,758,740	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,272,276	$ 102,492		$ 109,405	$ 6,913	$ 1,758,740	1
2	Garage	2002	71,872	154	35	154		154	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,344,148	$ 102,646		$ 109,559	$ 6,913	$ 1,758,894	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 470,992	$ 44,180	$ 44,180	$	5-15 yrs	$ 275,807	71
72	Current Year Purchases	12,715	1,039	1,039		5-15 yrs	1,039	72
73	Fully Depreciated Assets	288,534	1,386	1,386		5-15 yrs	288,534	73
74								74
75	TOTALS	$ 772,241	$ 46,605	$ 46,605	$		$ 565,380	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient transport	2000 Chev. Supreme Bus	1999	$ 43,000	$ 7,167	$ 7,167	$	6	$ 23,293	76
77	Patient transport	2002 Olds Silhoutte	2001	28,690	4,782	4,782		6	5,977	77
78										78
79										79
80	TOTALS			$ 71,690	$ 11,949	$ 11,949	$		$ 29,270	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,244,003	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 161,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,113	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,913	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,353,544	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment land improvements	$ 62,383	$ 2,853	$ 50,150	86
87	Apartments	1,416,814	40,621	640,771	87
88	Portraits	6,000			88
89	Equipment	22,911	1,872	11,351	89
90					90
91	TOTALS	$ 1,508,108	$ 45,346	$ 702,272	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Training was not necessary because this organization had a very low turnover rate of aides this year.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	NONE	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 500,523	$	1
2	Cash-Patient Deposits	5,735		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	244,496		3
4	Supply Inventory (priced at FIFO cost)	15,725		4
5	Short-Term Investments	2,210,956		5
6	Prepaid Insurance	15,285		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	14,320		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,007,040	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,924		13
14	Buildings, at Historical Cost	4,635,243		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	872,840		16
17	Accumulated Depreciation (book methods)	(2,928,674)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements, Hist. Cost	177,932		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,813,265	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,820,305	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,574	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,735		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,793		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Care Prepayments	4,616		36
37	Employee Health Insurance Withheld	7,761		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 168,479	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Apartment Resident Deposits	1,125,366		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,125,366	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,293,845	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,526,460	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,820,305	$	48

***(See instructions.)**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,766,218	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,766,218	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,758)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (239,758)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,526,460	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,719,741	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,719,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	351,423	24
25	Interest and Other Investment Income***	78,718	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 430,141	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	SEE PAGE 25	(257,231)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (257,231)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,892,651	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	794,454	31
32	Health Care	1,485,558	32
33	General Administration	579,441	33
	B. Capital Expense		
34	Ownership	206,704	34
	C. Ancillary Expense		
35	Special Cost Centers	16,977	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,132,409	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,758)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,758)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	2,081	$ 49,123	$ 23.61	1
2	Assistant Director of Nursing	1,784	2,083	44,484	21.36	2
3	Registered Nurses	7,435	7,965	151,671	19.04	3
4	Licensed Practical Nurses	23,766	25,658	397,810	15.50	4
5	Nurse Aides & Orderlies	53,334	57,816	551,192	9.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,324	5,045	60,472	11.99	8
9	Activity Director	1,630	2,058	23,305	11.32	9
10	Activity Assistants	3,227	3,534	22,463	6.36	10
11	Social Service Workers	1,860	2,053	22,478	10.95	11
12	Dietician					12
13	Food Service Supervisor	1,758	2,046	26,816	13.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,831	24,466	203,992	8.34	15
16	Dishwashers					16
17	Maintenance Workers	3,840	4,450	68,411	15.37	17
18	Housekeepers	9,363	10,117	74,887	7.40	18
19	Laundry	4,514	4,944	47,560	9.62	19
20	Administrator	1,928	2,121	59,927	28.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,805	2,115	34,152	16.15	23
24	Clerical	2,894	3,113	32,126	10.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,673	7,265	69,150	9.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,878	168,930	$ 1,940,019 *	$ 11.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 8,315	1 (3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	41	1,813	10 (3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	9	617	10(3)	40
41	Occupational Therapy Consultant	9	618	10(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	71	3,950	12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	322	$ 15,313		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Russell	Administrator	0	$ 59,927
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,927

B. Administrative - Other

Description	Amount
Flowers $917, Copier expense $1873, Fruit $184	$ 2,974
Safe dep. box rent $18, Corp. franchise fee $5, Investment fee $25	48
Medicare application & training	1,100
Heritage equipment agreement	356
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 4,478

C. Professional Services

Vendor/Payee	Type	Amount
Helen M. Meagher, C.P.A.	Audit, cost report & 990	$ 6,000
Duane Morris, LLP	Legal services	21,739
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 27,739

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,948
Unemployment Compensation Insurance	0
FICA Taxes	145,922
Employee Health Insurance	115,458
Employee Meals	69,917
Illinois Municipal Retirement Fund (IMRF)*	0
Workers' Compensation Deductible	690
Employee Physicals	1,504
Employee Awards	2,357
Fruit/Snacks for Employees	2,755
TOTAL (agree to Schedule V, line 22, col.8)	$ 390,551

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	5,340
Health Care Worker Background Check	
(Indicate # of checks performed 34)	398
Facility Advertising	59
Administrator License	150
Life Services Network of IL dues	4,849
Less: Public Relations Expense	( )
Non-allowable advertising	(59)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,737

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Employee local auto use reimbursement	42
Seminar Expense	
SEE PAGE 25	1,524
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,566

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Circulating pump repairs	4/94	$ 2,156	5	$ 165	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
2	Generator repairs	7/96	1,528	5	306	306	177	0	0	0	0	0	0
3	Water heater mixing brd	1/97	3,892	5	778	778	780	0	0	0	0	0	0
4	Repair chiller	8/97	1,917	5	383	383	383	225	0	0	0	0	0
5	Paint & wallpaper	10/98	3,234	3	1,078	1,078	808	0	0	0	0	0	0
6	Repair walk-in freezer	9/99	1,746	5	116	349	349	349	349	234	0	0	0
7	Vinyl wall coverings	7/99	14,358	5	1,436	2,872	2,872	2,872	2,872	1,434	0	0	0
8	Chiller compressor replac	6/00	5,789	5	0	675	1,158	1,158	1,158	1,158	482	0	0
9	Repair chiller	7/02	2,975	5	0	0	0	248	595	595	595	595	347
10	Freezer repairs	6/02	2,369	5.				237	474	474	474	474	236
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 39,964		$ 4,262	$ 6,441	$ 6,527	$ 5,089	$ 5,448	$ 3,895	$ 1,551	$ 1,069	$ 583

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network of IL - $4,849**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **19,947** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **49,275**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **69,917** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **3,072**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Helen M. Meagher, C.P.A.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

V. COST CENTER EXPENSES

A. General Services		Other
Line 7 Other:		
Hazardous Waste Removal		2,376
Rent - storage building		180
	$	2,556
E. Special Cost Centers		
Line 43 Other:		
Supplies, column 2		
Supplies for apartments	$	682
Other, column 3		
Apartment Expenses:		
Maintenance		5,589
Utilities		779
Trash Removal		1,152
Cable		2,840
Insurance		5,921
Auto mileage reimbursement		14
	$	16,295

V. RECLASSIFICATOINS

Description	To Line	From Line	Amount
1 Employee Meal Costs	22		69,917
		1	(36,889)
		2	(33,028)
2 CDS Copier Service	6		1,873
		17	(1,873)
3 Apartment Depreciation	43		45,346
		30	(45,346)
4 Employee Background Checks	20		398
		22	(398)
5 Storage Shed Rental	34		180
		7	(180)
6 Heritage Equipment Agreement	6		356
		17	(356)

XIX. SUPPORT SCHEDULES

G. Schedule of Travel and Seminar

Description	Amount
In-State Travel	
	$
TOTAL In-State Travel	$ 0

Seminar Expense	Date	Location	Amount
IL Healthcare Assoc. - DPA 2700 Inspection of Car	02/20/02	Springfield	$ 200
Illinois Healthcare Assoc. - IOC Provider Training	03/06/02	Springfield	330
2002 IAPA Convention	10/24-25/02	Decatur	330
SIU School of Medicine - Celebrate CNA's	10/01/02	Springfield	50
Food Service Solutions	11/21/02	Eureka	89
IL Central Dist. Dietary Manager Meeting	10/18/02	Galesburg	25
Occupational Rehabilitation Aide Course	2/25-27/02	Belleville	500
TOTAL Seminar Expense			$ 1,524

XVII. INCOME STATEMENT

E. Other Revenue

Description	Amount
Apartment Income	$ 50,027
Loss on Disposal of Equipment	(378)
Loss on Sale of Marketable Securities	(11,906)
Unrealized Depreciation of Investments	(294,974)
TOTAL Other Revenue	$ (257,231)